

# Your summary of benefits



Anthem® Blue Cross Life and Health Insurance Company

Your Plan: PRISM (San Luis Obispo County): High Deductible Health Plan

Your Network: Prudent Buyer PPO

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Overall Deductible</b>	\$2,000 person / \$6,000 family	\$2,000 person / \$6,000 family
<b>Out-of-Pocket Limit</b>	\$6,350 person / \$12,700 family	\$6,600 person / \$15,000 family
<p>When more than a single person is enrolled, the per person deductible does not apply and the family deductible must be met by any one person or collection of persons, but each is capped at his or her per person out-of-pocket maximum for covered services applied to the family deductible.</p> <p>Your copays, coinsurance and deductible count toward your out of pocket amount(s).</p> <p>In-network and out-of-network deductibles and out-of-pocket maximum amounts accumulate separately and do not accumulate toward each other.</p>		
<b>Preventive Care / Screening / Immunization</b>	No charge	40% coinsurance after deductible is met
<b>Preventive Care for Chronic Conditions</b> <i>per IRS guidelines</i>	No charge	40% coinsurance after deductible is met
<b><u>Virtual Care (Telemedicine / Telehealth Visits)</u></b>		
<b>Virtual Visits - Online visits with Doctors who also provide services in person</b>		
Primary Care (PCP) including Mental Health and Substance Abuse care by a PCP	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Mental Health and Substance Abuse care by Providers other than a PCP	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Specialist	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Virtual Visits from Online Provider LiveHealth Online</b> via <a href="http://www.livehealthonline.com">www.livehealthonline.com</a> ; our mobile app, website or Anthem-enabled device  Primary Care (PCP) and Mental Health and Substance Use Disorder  Specialist Care	  20% coinsurance after deductible is met  20% coinsurance after deductible is met	
<u><b>Visits in an Office</b></u>  <b>Primary Care (PCP)</b>  <b>Specialist Care</b>	  20% coinsurance after deductible is met  20% coinsurance after deductible is met	  40% coinsurance after deductible is met  40% coinsurance after deductible is met
<u><b>Other Practitioner Visits</b></u>  <b>Routine Maternity Care</b> (Prenatal and Postnatal)  <b>Retail Health Clinic</b>  <b>Manipulation Therapy</b> <i>Coverage is limited to 30 visits per benefit period.</i> <b>Acupuncture</b> <i>Coverage is limited to 20 visits per benefit period.</i>	  20% coinsurance after deductible is met  20% coinsurance after deductible is met  20% coinsurance after deductible is met  20% coinsurance after deductible is met	  40% coinsurance after deductible is met  40% coinsurance after deductible is met  40% coinsurance after deductible is met  40% coinsurance after deductible is met
<u><b>Other Services in an Office</b></u>  <b>Allergy Testing</b>  <b>Chemo/Radiation Therapy</b>  <b>Dialysis/Hemodialysis</b>  <b>Prescription Drugs</b> <i>Dispensed in the office</i>  <b>Surgery</b>	  20% coinsurance after deductible is met  20% coinsurance after deductible is met  20% coinsurance after deductible is met  20% coinsurance after deductible is met  20% coinsurance after deductible is met	  40% coinsurance after deductible is met  40% coinsurance after deductible is met  40% coinsurance after deductible is met  40% coinsurance after deductible is met  40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b><u>Diagnostic Services</u></b> <b>Lab</b> Office Freestanding Lab Outpatient Hospital	20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met	40% coinsurance after deductible is met 40% coinsurance after deductible is met 40% coinsurance after deductible is met
<b>X-Ray</b> Office Freestanding Radiology Center Outpatient Hospital	20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met	40% coinsurance after deductible is met 40% coinsurance after deductible is met 40% coinsurance after deductible is met
<b>Advanced Diagnostic Imaging</b> <i>for example: MRI, PET and CAT scans</i> Office Freestanding Radiology Center Outpatient Hospital	20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met	40% coinsurance after deductible is met 40% coinsurance after deductible is met 40% coinsurance after deductible is met
<b><u>Emergency and Urgent Care</u></b> <b>Urgent Care</b> <b>Emergency Room Facility Services</b> <b>Emergency Room Doctor and Other Services</b> <b>Ambulance</b>	20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met	40% coinsurance after deductible is met Covered as In-Network Covered as In-Network Covered as In-Network

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b><u>Outpatient Mental Health and Substance Use Disorder</u></b> <b>Doctor Office Visit</b>  <b>Facility Visit</b> Facility Fees  Doctor Services	20% coinsurance after deductible is met   20% coinsurance after deductible is met  20% coinsurance after deductible is met	40% coinsurance after deductible is met   40% coinsurance after deductible is met  40% coinsurance after deductible is met
<b><u>Outpatient Surgery</u></b> <b>Facility Fees</b> Hospital  Freestanding Surgical Center  <b>Doctor and Other Services</b> Hospital	20% coinsurance after deductible is met  20% coinsurance after deductible is met  20% coinsurance after deductible is met	40% coinsurance after deductible is met  40% coinsurance after deductible is met  40% coinsurance after deductible is met
<b><u>Hospital (Including Maternity, Mental Health and Substance Use Disorder)</u></b> <i>Anthem's maximum payment is up to \$600 per day for non-emergency Inpatient admissions to Non-Network Providers.</i> <b>Facility Fees</b>  <b>Doctor and other services</b>	20% coinsurance after deductible is met  20% coinsurance after deductible is met	40% coinsurance after deductible is met  40% coinsurance after deductible is met
<b><u>Recovery &amp; Rehabilitation</u></b> <b>Home Health Care</b> <i>Coverage is limited to 100 visits per benefit period.</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<b>Rehabilitation services</b>  Office  Outpatient Hospital	20% coinsurance after deductible is met  20% coinsurance after deductible is met	40% coinsurance after deductible is met  40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Cardiac rehabilitation</b> Office Outpatient Hospital	20% coinsurance after deductible is met 20% coinsurance after deductible is met	40% coinsurance after deductible is met 40% coinsurance after deductible is met
<b>Skilled Nursing Care (facility)</b> <i>Coverage is limited to 100 days per benefit period.</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<b>Inpatient Hospice</b>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<b>Durable Medical Equipment</b>	50% coinsurance after deductible is met	50% coinsurance after deductible is met
<b>Prosthetic Devices</b>	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
<b>Pharmacy Deductible</b>	Combined with medical deductible	Combined with medical deductible
<b>Pharmacy Out-of-Pocket Limit</b>	Combined with In-Network medical out-of-pocket limit	Combined with Non-Network medical out-of-pocket limit
<b>Prescription Drug Coverage</b> Cost shares for drugs included on the National drug list appear below. Your plan uses the Base Network. If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply. You may receive up to a 90 day supply of medication at Retail 90 pharmacies.		
<b>Home Delivery Pharmacy</b> Maintenance medication are available through IngenioRx Home Delivery Pharmacy. You will need to call us on the number on your ID card to sign up when you first use the service.		
<b>Preventive Drugs</b> Your Pharmacy cost share is waived for drugs included on the PreventiveRX Plus drug list, a designated list of drugs for the treatment of diabetes, asthma, depression, heart health, high blood pressure, high cholesterol, and osteoporosis.		
<b>Tier 1 Preventive - Typically Generic</b> Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).	No charge (retail) and Not covered (home delivery)	50% coinsurance up to \$250 per prescription after deductible is met (retail) and Not covered (home delivery)
<b>Tier 2 Preventive - Typically Preferred Brand</b> Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).	No charge (retail) and Not covered (home delivery)	50% coinsurance up to \$250 per prescription after deductible is met (retail) and Not covered (home delivery)
<b>Tier 1 - Typically Generic</b> Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).	20% coinsurance after deductible is met (retail and home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
<b>Tier 2 – Typically Preferred Brand</b> Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).	20% coinsurance after deductible is met (retail and home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
<b>Tier 3 - Typically Non-Preferred Brand</b> Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).	20% coinsurance after deductible is met (retail and home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
<b>Tier 4 - Typically Specialty (brand and generic)</b> <i>Per 30 day supply (specialty pharmacy).</i>	20% coinsurance after deductible is met (retail and home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)

**Notes:**

- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under “Outpatient Facility Services”.
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- Outpatient Facility tests and treatments are limited to \$350 per day for Non-Network Providers. Includes Diagnostic Services, X-ray, Surgery, Rehabilitation, Habilitation, and Cardiac Therapy. This also includes Surgery at Freestanding Facilities. Advanced Diagnostic Imaging is limited to \$800 per test for Non-Network Providers.
- Coverage includes standard fertility preservation services as a basic healthcare service including but are not limited to, injections, cryopreservation and storage for both male and female members when a medically necessary treatment may cause iatrogenic infertility. Member cost share for fertility preservation services is based on provider type and service rendered.

*This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.*

Your Plan: PRISM (San Luis Obispo County): High Deductible Health Plan

Your Network: Prudent Buyer PPO

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate, and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

By signing this Summary of Benefits, I agree to the benefits for the product selected as of the effective date indicated.

Authorized group signature (if applicable)	Date
Underwriting signature (if applicable)	Date

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# Get help in your language

## Notice of Language Assistance



Curious to know what all this says? We would be too. Here's the English version:

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-888-254-2721. For more help call the CA Dept. of Insurance at 1-800-927-4357. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

### Spanish

Servicios lingüísticos sin costo. Puede tener un intérprete. Puede solicitar que le lean los documentos y algunos puede recibirlos en su idioma. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-888-254-2721. Para obtener ayuda adicional, llame al Departamento de Seguros de California al 1-800-927-4357. (TTY/TDD: 711)

### Arabic

يتم تقديم خدمات اللغة دون مقابل. يمكنك الاستعانة بترجم. ويمكنك المطالبة بأن تُقرأ لك بعض المستندات وأن يُرسل بعضها بلغتك. للحصول على المساعدة، اتصل بنا على الرقم الموجود على بطاقة التعريف الخاصة بك أو على الرقم 1-888-254-2721. للحصول على مزيد من المساعدة، يُرجى الاتصال بإدارة كاليفورنيا للتأمين على الرقم 1-800-927-4357. (TTY/TDD: 711)

### Armenian

Թարգմանչական անվճար ծառայություններ: Մենք կարող ենք Ձեզ թարգմանչի ծառայություններ առաջարկել Կարող ենք տրամադրել ինչ-որ մեկին, ով փաստաթղթերը կկարդա Ձեզ համար և կուղարկի դրանք Ձեր լեզվով: Օգնություն ստանալու համար զանգահարեք մեզ Ձեզ ID քարտի վրա նշված հեռախոսահամարով կամ 1-888-254-2721 համարով: Լրացուցիչ օգնության համար զանգահարեք Կալիֆոռնիայի ապահովագրության նախարարություն հետևյալ հեռախոսահամարով՝ 1-800-927-4357: (TTY/TDD: 711)

### Chinese

免費語言服務。您能獲得免費的譯員。您能聽到以您的語言讀出的文件內容，也能獲得以您的語言而寫的部分文件。如需協助，請撥打您的 ID 卡上的號碼或者1-888-254-2721聯絡我們。如需更多協助，請撥打1-800-927-4357 聯絡CA Dept. of Insurance。(TTY/TDD: 711)

### Farsi

خدمات رایگان زبانی. می‌توانید یک مترجم شفاهی بگیرید. می‌توانید بخوانید اسناد را برای شما بخوانند و برخی اسناد نیز به زبان خودتان برایتان ارسال شود. برای دریافت کمک، از طریق شماره فهرست شده در کارت شناسایی‌تان و یا از طریق 1-888-254-2721 با ما تماس بگیرید. برای دریافت کمک‌های بیشتر با اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تماس بگیرید. (TTY/TDD: 711)

### Hindi

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बिना लागत की भाषा सेवाएँ। आप दुभाषिया प्राप्त कर सकते हैं। आप दस्तावेज़ पढ़वा सकते हैं और कुछ दस्तावेज़ आपको आपकी भाषा में भेजे जा सकते हैं। मदद के लिए, हमें अपने ID कार्ड पर सूचीबद्ध नंबर पर या 1-888-254-2721 पर कॉल करें। अधिक मदद के लिए 1-800-927-4357 पर CA बीमा विभाग कोकॉल करें। (TTY/TDD: 711)

**Hmong**  
Tsis Xam Tus Nqi Cov Kev Pab Cuam Ntsig Txog Hom Lus. Koj muaj peev xwm tau txais ib tus neeg txhais lus. Koj muaj peev xwm tau txais cov ntaub ntawv nyeem ua koj hom lus rau koj mloog thiab yuav xa ib co ntaub ntawv sau ua koj hom lus tuaj rau koj. Txog rau kev pab, hu rau peb tus nab npawb xov tooj teev tseg cia nyob rau ntawm koj daim ID los sis 1-888-254-2721. Txog rau kev pab ntxiv, hu xov tooj rau Pab Kas Phais Lub Chaw Ua Hauj Lwm CA tus xov tooj 1-800-927-4357. (TTY/TDD: 711)

**Japanese**  
無料言語サービス。通訳サービスを受けられます。希望する言語で文書を読み上げたり、文書を送るサービスも可能です。支援を受けるには、IDカードに記載された番号、または 1-888-254-2721 にお電話ください。支援の詳細は、カリフォルニア州保険局（1-800-927-4357）にお電話ください。(TTY/TDD: 711)

**Khmer**  
សេវាភាសាឥតគិតថ្លៃ។ អ្នកអាចទទួលបានសេវាបកប្រែឥតគិតថ្លៃ។ អ្នកអាចឱ្យគេអានឯកសារឱ្យស្តាប់ឬអាន និងផ្ញើឯកសារជូនអ្នកជាភាសាខ្មែរ។ ដើម្បីទទួលបានសេវា តាមរយៈ ទូរស័ព្ទសេរីសាមគ្គីភាពស្ថាប័នដែលបានកំណត់លើកាត ID របស់អ្នក ឬក៏លេខ 1-888-254-2721។ ដើម្បីទទួលបានជំនួយបន្ថែម តាមរយៈទូរស័ព្ទសេរីសាមគ្គីភាព CA Dept. of Insurance តាមលេខ 1-800-927-4357។ (TTY/TDD: 711)

**Korean**  
무료 언어 서비스. 번역사를 이용하실 수 있습니다. 귀하의 언어로 녹음되어 작성된 문서를 받아보실 수 있습니다. 도움을 받으시려면 ID 카드에 기재된 번호 또는 1-888-254-2721로 전화하십시오. 다른 도움이 필요하시면 1-800-927-4357로 보험 CA 부서에 문의 주십시오. (TTY/TDD: 711)

**Punjabi**  
ਭੋਜਪੁਰੀ ਭਾਸ਼ਾ ਦੀ ਸੇਵਾ ਬਿਨਾਂ ਕਿਸੇ ਭਾਰਤ ਦੇ। ਅਸੀਂ ਤੁਹਾਨੂੰ ਆਪਣੇ ਭਾਸ਼ਾ ਵਿੱਚ ਦਸਤਾਵੇਜ਼ਾਂ ਪੜ੍ਹਾਉਣ ਦੇ ਸੇਵਾ ਦਿੰਦੇ ਹਾਂ। ਜੇ ਤੁਹਾਨੂੰ ਸਹਾਇਤਾ ਦੀ ਜ਼ਰੂਰਤ ਹੈ, ਤਾਂ 1-888-254-2721 'ਤੇ ਆਪਣੇ ID ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਜਾਂ 1-800-927-4357 'ਤੇ ਆਪਣੇ ਭਾਗੀਦਾਰ ਨੂੰ ਆਪਣੇ ਭਾਸ਼ਾ ਵਿੱਚ ਦੱਸੋ। (TTY/TDD: 711)

**Russian**  
Бесплатные языковые услуги. Вы можете получить услуги устного переводчика. Вам могут прочесть документы или направить некоторые из них на вашем языке. Для получения помощи звоните нам по телефону, указанному на вашей идентификационной карте, или по номеру 1-888-254-2721. Для получения дополнительной помощи звоните в Департамент страхования штата Калифорния по номеру 1-800-927-4357. (TTY/TDD: 711)

**Tagalog**  
Mga Libreng Serbisyo para sa Wika. Maaari kayong kumuha ng interpreter. Maaari ninyong ipabasa ang mga dokumento at ipadala ang ilan sa mga ito sa inyo sa wikang ginagamit ninyo. Para sa tulong, tawagan kami sa numerong nakalista sa inyong ID card o sa 1-888-254-2721. Para sa higit pang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357. (TTY/TDD: 711)

**Thai**  
ไม่มีค่าบริการเกี่ยวกับภาษา ท่านสามารถขอใช้บริการได้  
ท่านสามารถขอให้เจ้าหน้าที่อ่านเอกสารได้ท่านฟังและเอกสารบางอย่างจะส่งถึงท่านโดยใช้ภาษาของท่าน หากต้องการความช่วยเหลือโปรดโทรหาเราตามหมายเลขที่ระบุอยู่บนบัตรประจำตัวของท่านหรือที่หมายเลข 1-888-254-2721 หากต้องการความช่วยเหลือเพิ่มเติมโปรดโทรติดตามแผนก CA Dept. of Insurance ที่หมายเลข 1-800-927-4357 (TTY/TDD: 711)

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Vietnamese

Các Dịch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể có thông dịch viên. Quý vị có thể yêu cầu đọc tài liệu cho quý vị nghe và yêu cầu gửi một số tài liệu bằng ngôn ngữ của quý vị cho quý vị. Để được trợ giúp, hãy gọi cho số được ghi trên thẻ ID của quý vị hoặc số 1-888-254-2721. Để được giúp đỡ thêm, hãy gọi cho Sở Bảo Hiểm California (California Department of Insurance) theo số 1-800-927-4357. (TTY/TDD: 711)

### **It's important we treat you fairly**

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

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